BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
Bach Kim Nguyen, M.D.	)	**Case No. 800-2014-007285**
Physician's and Surgeon's Certificate No. A 92027	)	
Respondent	)	

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on May 30, 2018.

IT IS SO ORDERED: April 30, 2018.

MEDICAL BOARD OF CALIFORNIA

Kristina D. Lawson, J.D., Chair
Panel B

XAVIER BECERRA
Attorney General of California
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **BACH KIM NGUYEN, M.D.** **41680 Ivy Street, Suite #A** **Murrieta, CA 92562** **Physician's and Surgeon's Certificate No. A 92027** Respondent.	Case No. 800-2014-007285 OAH No. 2017081161 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Colleen M. McGurrin, Deputy Attorney General.

2. BACH KIM NGUYEN, M.D. (Respondent) is represented in this proceeding by attorney Frederick M. Ray, Esq., whose address is: Law Offices of Ray & Bishop, 5000 Birch Street, Suite 7000, Newport Beach, California 92660.

3. On or about July 1, 2005, the Board issued Physician's and Surgeon's Certificate No. A 92027 to Respondent. Said Certificate was in full force and effect at all times relevant to the

charges brought in Accusation No. 800-2014-007285, and will expire on November 30, 2018, unless renewed.

JURISDICTION

4. Accusation No. 800-2014-007285 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on July 31, 2017. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2014-007285 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2014-007285. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent freely, voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2014-007285, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that he does not contest that, at an administrative hearing,

Complainant could establish a *prima facie* case with respect to the charges and allegations contained in Accusation No. 800-2014-007285, and that he hereby gives up his right to contest those charges thereby subjecting his license to disciplinary action.

11. Respondent agrees that if he ever petitions for early termination or modification of probation, or if the Board ever petitions for revocation of probation or any other action against him, all of the charges and allegations contained in Accusation No. 800-2014-007285 shall be deemed true, correct and fully admitted by Respondent for purposes of that proceeding or any other licensing proceeding involving Respondent in the State of California.

12. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

13. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

14. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

15. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 92027 issued to Respondent BACH KIM NGUYEN, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years on the following terms and conditions.

1. CONTROLLED SUBSTANCES - MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all of the following: 1) the name and address of the patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

2. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 50 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 75 hours of CME of which 50 hours were in satisfaction of this condition.

3. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in

advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of

this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

5. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring

responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

6. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

7. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

8. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

9. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty

(30) calendar days.

In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

10. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

11. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Boards' Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

12. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

13. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

14. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

15. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which

may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Frederick M. Ray, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order freely, voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 01/31/2018

BACH KIM NGUYEN, M.D.
Respondent

I have read and fully discussed with Respondent BACH KIM NGUYEN, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 1/31/18

FREDERICK M. RAY, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated: 2/1/2018

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General

COLLEEN M. MCGURRIN
Deputy Attorney General
Attorneys for Complainant

LA2017605059; 2946569

Exhibit A

Accusation No. 800-2014-007285

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **BACH KIM NGUYEN, M.D.** 41680 Ivy Street, Suite A Murrieta, California 92562 Physician's and Surgeon's Certificate No. A-92027, Respondent.	Case No. 800-2014-007285 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about July 1, 2005, the Medical Board issued Physician's and Surgeon's Certificate Number A-92027 to Bach Kim Nguyen, M.D. (Respondent). At all times relevant to the matters set forth below, said license has been in full force and effect and will expire, unless renewed, on November 30, 2018.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the Patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

6. Section 2266 of the Code states: AThe failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their Patients constitutes unprofessional conduct.@

CASE SUMMARY

7. Mr. "J.H." (hereinafter "the Patient") was a 33-year-old man with a history of alcohol use, chronic back pain, anxiety, insomnia, and gastroesophageal reflux disease when he started to see Respondent. He established care with Respondent at the Ivy Springs Medical Care clinic on March 31, 2010.

8. During his initial visit on March 31, 2010, Respondent documented a full history and physical including past medical history, past surgical history, social history, substance use history, review of systems, exam, assessment and plan. The substance use history documented that the Patient was a non-smoker and "beer was consumed weekly." He also documented that the back pain was "on/ off for the past several years" and that the "condition once in a while will flare up with lower back pain across the lower back." He noted a "history of lower back injury." Back pain was "not constant" and "no pain radiating down to the leg." His Review of Systems included the statements: "absent gait disturbance" and "negative psychiatric symptoms" and no "fevers, night sweats." The Patient was diagnosed by the Respondent with lumbago and reflux esophagitis and prescribed Prilosec OTC, Robaxin 750 mg q4h, and Norco 10/325 mg q4-6h prn. Respondent stated in his interview that he wanted to avoid NSAIDS because of his history of gastritis and acid reflux.

9. On his second visit May 4, 2010, the Patient was noted to have a "history of lower

back injury from sports." It was noted that the Patient had "a flare up for his lower back lately and has been having "neck spasms." "No radiation down arms or legs." The Review of Systems for this visit was essentially the same as the initial visit but neck spasms were added. The examination included an exam of the neck and back and documented a "negative straight leg raise test." The Patient was changed to Soma TID (#90) and continued on Norco 10/325 (#90).

10. A visit on June 4, 2010, documented insomnia periodically. The Review of Systems was essentially the same as the initial visit. Exam of back is "negative for radiculopathy." Respondent recommended ice/warm compresses TID, moderate exercise and refilled Norco 10/325 (#90) and Soma (#90).

11. A visit on June 29, 2010, documented improved insomnia and the Patient "denies any side effects from the medications." His Review of Systems was essentially the same as the initial visit. The Patient's back was examined and the notation made, "paraspinal muscle spasm and negative straight leg raise test. Recommended ice/warm compresses TID, exercise and ibuprofen prn and use of soma and Norco prn. Refilled Norco 10/325 (#90) and Soma (#90). Recommended ice/warm compresses and exercise."

12. A visit on July 28, 2010, documented that "soma and Norco are working well for him" to control lower back pain. He [the Patient] does report a "constant heartburn sensation, especially at night." "No tar or blood in stools." Exam with epigastric tenderness. Switched from Prilosec OTC to Nexium 40 mg daily. Refilled Norco 10/325 (#90) and Soma (#90). Recommended ice/warm compresses and exercise.

13. The August 30, 2010, visit documented good control of back pain. Able to drive long distances every day. Desires lab work. Review of symptoms with no abdominal pain. Adequate exam for symptoms performed. Refilled Norco 10/325 (#90) and Soma (#90). Recommended ice/warm compresses and exercise.

14. A September 29, 2010, visit documents a "lump under left arm." Exam documented a "pea-sized lump in the left axillary area with no erythema, discharge and small opening in middle." Diagnosed with hidradenitis and recommended observation. Review of Systems essentially the same as initial visit, except now is positive for "psychiatric symptoms and

insomnia." For lumbago, the Respondent documented "discussed with the Patient and will stop the Norco, but start Patient on oxycodone 15 mg q.i.d (#120) and continue soma QID." Recommended ice/warm compresses and exercise.

15. October 27, 2010, and November 24, 2010, visits were similar with description of lower back pain "worsening with prolonged driving which is his career." Review of Systems essentially the same as the initial visit, except now is positive for "psychiatric symptoms and insomnia." Patient was continued on oxycodone 15 mg q.i.d and continue Soma QID. Recommended ice/warm compresses and exercise.

16. During the clinic visits on December 22, 2010, and January 26, 2011, there was an escalation of the oxycodone dosage to 20 mg tablets initially then 30 mg tablets. Notes record that the Patient "denies any side effects so far." Review of Systems is essentially the same as initial visit, except now is positive for "psychiatric symptoms and insomnia." Temazepam 30 mg at bedtime was also added as needed for insomnia. Recommended ice/warm compresses and exercise.

17. On the clinic visit of April 11, 2011, Respondent documented that "For the past month, due to weather changes, Patient has been having worsening of the lower back pain, mostly on the left side." Back exam with paraspinal muscle tenderness. Oxycodone increased to 30 mg q4h prn (#120 prescribed). Respondent also added diazepam 10 mg bid prn for muscle spasm. Recommended ice/warm compresses and exercise. When asked in his interview if he ever considered doing more diagnostic testing for back pain besides giving the Patient pain medication, Respondent replied that he "always advise the Patients that he need to have more studies done including X-ray or MRI. I also advised the Patients to go for physical therapy, and also a referral to pain management. However, the Patients all those time they are declining." When pressed during his interview that the Patient's "pain level hasn't gotten better, but instead it got worse. So did that cause you any concern that increasing the dosage of the medication didn't seem to treat this problem?" Respondent responded "yes" but qualified his response by stating that he "did offer the Patient consulting with a spine specialist and the pain specialist as well as physical therapy and again the Patient decline."

18. On June 22, 2011, in the clinic, the Patient complained of malaise and fatigue. Review of Systems now is positive for depression, anxiety, difficulty concentrating, and sleep disturbance. Exam unchanged. Patient continued on oxycodone 30 mg 5x/day, Soma TID, Ambien 10 mg qhs prn, and was started on lorazepam bid and diazepam was stopped. Recommended ice/warm compresses and exercise. No referrals made.

19. At the July 18, 2011, visit, the Patient reported "having increase of stress and anxiety lately with no able to sleep at night time." Exam unchanged. Lorazepam discontinued and started on Xanax 0.5 mg TID prn. Patient continued on oxycodone and Ambien, but Soma discontinued. Recommended ice/warm compresses and exercise. No referrals made. The Patient's medical condition for his chronic low back pain, anxiety, and insomnia were fairly stable between July 18, 2011, until September 7, 2011. No medication changes were made.

20. On September 7, 2011, the Patient was seen and stated that he developed nausea, vomiting, diarrhea and body cramps after he "stopped the medications about a week ago due to employment drug screening." The Patient was diagnosed with drug withdrawal and given an intramuscular injection of Zofran 4 mg and a prescription for Phenergan 25 mg q4h prn. He then refilled prescriptions for oxycodone, Xanax, and Ambien. No referral was made. Respondent acknowledged that he was aware that the Patient was dependent on narcotics at this point.

21. On June 15, 2012, the clinic note mentions that the Patient has a history of ADD (attention deficit disorder) and anxiety and he has been under a lot of stress due to "wife's work issue" and having problems sleeping at night. Exam remarkable for epigastric tenderness. Patient referred to GI specialist for an esophagogastroduodenoscopy for longstanding GERD. Xanax dose increased to 1 mg TID prn. Patient continued on oxycodone and Ambien.

22. On his August 1, 2012, visit, the Patient complained of "increase of anxiety and stress with depression [due to many] issues going on with him and his family." Exam unchanged. The Patient was given a work excuse for six months. Continued on oxycodone, Ambien, and Xanax. No referral made. Respondent stated that he diagnosed depression "mostly with questionnaires and Patients' report," but he never had Patient complete a questionnaire. Respondent did not even have a depression questionnaire available in his office at that time.

23. During the period between August 1, 2012, and January 15, 2013, the Patient continued to have the same symptoms. He had ongoing anxiety, depression and insomnia because both he and his wife were now unemployed and on disability. The Patient was continued on the same doses of oxycodone, Ambien, and Xanax. Respondent did recommend "behavior modification treatments," but did not elaborate on specifics and no mental health referral was made. No antidepressants were initiated.

24. On the March 4, 2013, clinic visit, the Patient reported that "lately stress has been high for which causing more panic attacks, constant under stress . . . and back has been flaring up with the amount of stress . . . " Exam unchanged. Continued on same doses of oxycodone and Ambien, but Xanax dose increased to 2 mg TID. No referral made.

25. At a May 20, 2013, clinic visit, the Patient stated "pain has been worse attributed to the changes in the weather." Exam unchanged. Flexeril 10 mg TID added to oxycodone, Xanax, and Ambien. The Patient's condition was fairly stable until he was seen on August 26, 2013 when he again stated that "pain has been worse attributed to the changes in the weather." Exam unchanged. Respondent told him to stop the oxycodone and start morphine sulfate IR 15 mg q4h prn. He was continued on Flexeril, Xanax, and Ambien.

26. On July 16, 2013, Respondent saw the Patient for follow-up and documented that the Patient has "long history of chronic lower back pain with spinal stenosis." When he was interviewed, Respondent was asked how he knew that the Patient had spinal stenosis. Respondent answered, "that's my clinical judgment . . . during my physical exam, the patient has worsening pain with hyperextension of his back and that's indicative of the patient having spondylosis and the underlying reason of spondylosis is degenerative disc disease and is causing the spinal canal narrowing." When asked to clarify what part of the spinal canal was narrowed, Respondent stated: "spinal stenosis, I'm referring to the central canal where the spinal cord is running inside." When asked about a referral to have a surgical consult, Respondent replied that he "did offer the patient to be seen by a pain specialist or spine specialist, however the Patient declined."

27. On his October 21, 2013 clinic visit, the Patient reported, "trying to get off of the medication, however, used EtOH [ethyl alcohol] with vodka for the condition. Patient went to

Disneyland and collapsed with seizure activities. Patient had about three of the episodes during the day. Patient biting his tongue causing laceration. Went to Anaheim Regional ER for treatments." Exam with "right side lateral tongue with laceration, healed well." Back exam unchanged. No neurologic exam done. Refilled prescriptions for oxycodone 30 mg q4h prn, Flexeril 10 mg TID, Xanax 2 mg TID, Ambien 10 mg qhs. "Advised the patient to stop using EtOH. Patient most likely having seizure with EtOH withdrawal." No referral made. No documented discussion about driving or DMV report. When interviewed Respondent was asked if he had any concerns about the seizures. He responded: "very straightforward that the patient was using vodka and he was drunk. He's also abruptly stopped all of his narcotic medication while he's been on it for a couple years; so that my judgment at that time he had the seizure from drug withdrawal." Respondent also did not perform a neurological exam or request medical records from Anaheim Regional Hospital, nor provided a referral to a neurologist nor enforced that the Patient should not be driving.

28. During a clinic visit on January 30, 2014, the Patient stated that he is "not able to focus [and] quite often finds himself become inattentive and easily distracted. Never been diagnosed with ADD [but] has positive family history of ADD." Exam unchanged. No neurologic or psychiatric assessment done. Prescribed Concerta 27 mg daily and "recommended seeking consultation from psychiatrist." No formal referral made.

29. Of note, during the entire period that the Patient was cared for at Ivy Springs Medical Care clinic for chronic low back pain, anxiety, depression, and insomnia, Respondent made no referrals to a physical therapist, a pain specialist, a neurologist, spine specialist, or a mental health professional. Respondent did state that he verbally offered this to the Patient but the Patient declined every time. These discussions were never documented in the chart.

30. Also, no random urine drug screening or intermittent CURES report checks were ever performed. Respondent acknowledged during his interview that he never performed a CURES report or random urine drug screening while the Patient was living. There was no narcotics contract signed. Respondent states that he had a "verbal agreement" with the Patient described as follows: "the patient's required to come to the office once a month and the patients can only

receive pain medication from myself and that Patient have to fill the prescription at the same pharmacy, if the Patient loses the prescription the Patient won't get any replacement, and if the Patient breaks the contract they will be discharged from the office . . . and the Patient is expected to have a drug screen unannounced." Respondent never checked to make sure that the Patient followed this verbal contract by running a CURES report or performing random urine drug testing. Also, no informed consent discussion of risks, benefits, and alternatives to chronic narcotics or benzodiazepines was documented in the chart. Respondent did state in his interview that he "does verbally advise the Patients of the risks and benefits of the medication that he is receiving, including dependency, addiction, overdose, and even death." Respondent then acknowledged, when asked if he ever documented this in the medical records, that he "did not."

31. Finally, Respondent never performed any imaging studies of the Patient's back during this four-year period of care. When asked in his interview if he ever considered doing more diagnostic testing for back pain besides giving the Patient pain medication, Respondent replied that he "always advise the Patients that he need to have more studies done including X-ray or MRI. I also advised the Patients to go for physical therapy, and also a referral to pain management. However, the Patients all those time they are declining." Respondent never documented that he advised radiologic imaging to the Patient and the Patient declined. Respondent did state "within a year" when asked "how recent should X-rays be in order for them to be reliable." Respondent even answered "yes" when asked "so [the Patient] was OK getting X-rays for his esophagus but not for his lower back which was his chief complaint?" The Patient did have a lumbosacral X-ray series performed on August 6, 2007 at the Hemet Valley Imaging Medical Group. The X-ray was ordered by Nathan Howard, M.D., and was unremarkable.

32. The Patient was found by his adolescent son unresponsive with agonal breathing on February 15, 2014. 911 was called and the Patient suffered a cardiac arrest and could not be resuscitated at the Chapman Hospital ER. He expired on that same day. His death certificate stated that the causes of death are myocarditis, encephalitis, meningitis and pneumonitis. His toxicology report found evidence of oxycodone, oxymorphone, alprazolam, diazepam, and

cyclobenzaprine in his system. The coroner's report revealed evidence of lymphocytic myocarditis, acute bronchopneumonia, aseptic meningoencephalitis, and cerebral edema.

33. Respondent received a telephone call on February 21, 2014, from the Patient's wife, Melissa, informing him that the Patient had passed away the previous Saturday and had been pronounced dead at Chapman Hospital ER. The Respondent recorded in his chart: "Autopsy underway, but wife informed the patient may have OD." Importantly, at no time between March 31, 2010, and February 15, 2014, did any family member or acquaintance of the Patient ever contact Respondent about an alcohol abuse problem. Respondent did receive a phone call from the Patient's sister in late February 2014 during which the sister informed him "that the patient was an alcoholic and had been drinking vodka every day for some time. The patient's sister additionally informed Dr. Nguyen that the patient had been taking other family members' medications including his wife and mother-in-law . . . she also reported that he had taken leftover morphine and Dilaudid . . . and reported the cause of death had been an overdose."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

34. Respondent Bach Kim Nguyen, M.D., is subject to disciplinary action under section 2234 subdivision (b) of the Code for acts of gross negligence in his care and treatment of the Patient. The circumstances are as follows:

Continuation of Chronic Narcotic and Benzodiazepine Prescribing with Evidence of Drug Addiction and Mental Illness

35. Prescribing opioids for patients with a history of substance abuse disorder is challenging because such patients are more vulnerable to drug misuse, abuse, and addiction. The standard of care requires that ongoing use of controlled substances should occur in a highly controlled setting that may include co-management with a pain specialist and addiction specialist. Use of chronic opioid therapy in patients with mental illness should only be for well-defined somatic or neuropathic pain conditions under close monitoring, and physicians should seek consultation from appropriate specialists.

36. Business and Professions Code section 2241.5 (d) states that: "A physician and surgeon shall exercise reasonable care in determining whether a particular patient or condition, or the complexity of a patient's treatment, including, but not limited to, a current or recent pattern of drug abuse, requires consultation with, or referral to, a more qualified specialist." The care of a patient with a history of substance abuse or addiction requires extra monitoring, documentation, and often consultation with an addiction specialist.

37. The Patient had an alcohol use disorder, evidence of opioid addiction, and a mood disorder with depression and anxiety. An opioid risk tool performed at the outset of care would have scored him as a moderate high risk candidate for chronic opioid therapy (depending on his family history of substance abuse which was not documented). Psychological screening and alcohol use disorder screening tests may have been positive as well.

38. Nevertheless, the Patient clearly was identified as having an opioid addiction problem by September 7, 2011. He was identified as having an alcohol use disorder definitely by October 21, 2013, and was diagnosed with mental illness as early as January 26, 2011.

39. The Patient was continued on chronic opioid and benzodiazepine therapy despite a substance abuse disorder, evidence of opioid and possibly benzodiazepine addiction, and a mood disorder. (No efforts were made to wean the chronic opioid and benzodiazepine therapy.) No referrals were made.

40. The continuation of chronic opioid and benzodiazepine therapy with no efforts to taper these controlled substances and no referrals to a pain specialist or addiction specialist or mental health specialist in a patient with definite alcoholism, opioid addiction, depression, and anxiety is an extreme departure from the standard of care.

Lack of Adjustment When Chronic Pain Treatment Plan Was Ineffective

41. The standard of care for prescribing controlled substances for pain requires the presence of a treatment plan with stated goals and objectives by which the treatment plan can be assessed prior to prescribing controlled substances. These objectives are summarized by the five "A's" method for chronic pain management assessment:

Analgesia: the patient has a reduction in pain

Activity: the patient is demonstrating an improved level of functioning.

Adverse: the patient is not experiencing any side effects

Aberrance: the patient is complying with the pain management agreement and there are no signs of medication abuse or diversion

Affect: the patient's behavior and mood are appropriate.

42. A treatment plan with stated objectives should be established for all patients receiving chronic narcotics for pain management. Respondent continued to escalate the chronic opioid therapy and benzodiazepine therapy even though the medication changes were not reducing the pain, the Patient developed medication side effects, developed a mood disorder, and had signs of addiction.

43. Despite a failing chronic pain management plan, he did not consult a pain specialist or addiction specialist or mental health professional.

44. The failure to adjust a failing chronic pain management plan, obtain consultations and the inappropriate escalation of chronic opioids and benzodiazepines even though the pain failed to improve and he developed evidence of drug addiction and a mood disorder is an extreme departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

45. Respondent Bach Kim Nguyen, M.D., is subject to disciplinary action under section 2234 subdivision (c) of the Code for repeated negligent acts. The circumstances are as follows.

Inadequate work-up and treatment for a patient with a recent seizure

46. A patient with a new-onset seizure should have a thorough examination and evaluation for the etiology of the seizure. This includes a thorough neurological examination, investigation into a metabolic abnormality, investigation into a structural brain abnormality (especially if a focal neurological deficit is apparent), investigation into an infectious etiology may be warranted, investigation into illicit drug use, and consideration of an electroencephalogram.

47. In addition, a patient with a recent seizure should not be driving, the patient must be

informed of this, and a DMV report must be filed (unless already done).

48. Respondent initially attributed the Patient's seizures to alcohol withdrawal, writing in the chart "patient most likely having seizure with EtOH withdrawal." However, in his interview he attributes the seizure to "drug withdrawal" that could have been benzodiazepine withdrawal or alcohol. When asked if he had any concerns about the seizures, Respondent responded that "very straightforward that the patient was using vodka and he was drunk. He's also abruptly stopped all of his narcotic medication while he's been on it for a couple years; so that my judgment at that time he had the seizure from drug withdrawal." Respondent also did not perform a neurological exam or request medical records from Anaheim Regional Hospital, provide a referral to a neurologist or enforce that the Patient should not be driving.

49. The lack of any neurological exam or work-up for a new-onset of seizure, lack of neurology referral, and lack of enforcement of no driving represents a simple departure from the standard of care.

Lack of Informed Consent for Use of Controlled Substances

50. The standard of care for prescribing controlled substances for pain requires that all patients receive informed consent about these medications including a discussion of the risks, benefits, and potential alternatives to chronic narcotic therapy.

51. Respondent stated that he provided informed consent prior to initiating chronic opioid and benzodiazepine therapy to the Patient; however, this consent was never documented in the chart.

52. The absence of any documentation of a narcotic or controlled substance use informed consent discussion represents a simple departure from the standard of care.

Insufficient use of diagnostic testing to establish cause of chronic lower back pain

53. All clinicians should perform a diligent investigation as to the cause of chronic nonmalignant pain. This includes a careful history and exam and may include radiologic assessment of the area, focused lab testing to narrow down a differential diagnosis, and potentially involve consultants to determine the etiology of the pain and suggest therapeutic modalities to help with pain management.

54. Respondent never performed any radiologic testing or specialized testing to determine the etiology of the Patient's chronic low back pain. Respondent clinically thought the Patient had central canal stenosis of the spine stating, "that's my clinical judgment . . . during my physical exam, the patient has worsening pain with hyper extension of his back and that's indicative of the patient having spondylosis and the underlying reason of spondylosis is degenerative disc disease and is causing the spinal canal narrowing." When asked to clarify what part of the spinal canal is narrowed, Respondent stated: "spinal stenosis, I'm referring to the central canal where the spinal cord is running inside."

55. Spinal stenosis can be suspected by clinical exam, but it must be confirmed using an MRI of the lumbar spine. Spondylosis must be confirmed using a lumbosacral X-ray series.

56. The insufficient use of radiologic imaging to confirm the etiology of chronic lower back pain is a simple departure from the standard of care.

Absence of a signed chronic narcotics contract

57. All patients who are prescribed chronic narcotics should have a documented and signed pain management agreement that outlines the joint responsibilities of the physician and the patient. Elements of such an agreement should include an acknowledgment by the patient that chronic opioid use may lead to addiction or overdose, that the patient will obtain his/her opioids and controlled substances by only one provider at one pharmacy, will take the medication only as prescribed, will undergo periodic random drug testing, will go to ancillary services when told to do so (physical therapy, counseling, consultations, etc.), will not drink alcohol or take street drugs, and will not participate in drug diversion.

58. Respondent stated that he had a verbal agreement with the Patient about chronic controlled substance use but nothing was signed or documented. Respondent states that he had a "verbal agreement" with the Patient that included "the patient's required to come to the office once a month and the patients can only receive pain medication from myself and that patient have to fill the prescription at the same pharmacy, if the patient loses the prescription the patient won't get any replacement, and if the patient breaks the contract they will be discharged from the office . . . and the patient is expected to have drug screen unannounced."

59. Not having a signed narcotics contract documented in the chart is a simple departure from the standard of care.

Insufficient compliance monitoring for patients on chronic opioids and controlled substances

60. All patients who are prescribed chronic controlled substances, especially chronic narcotics, should undergo a regular prescription drug monitoring program such as CURES (Controlled Substances Utilization Review and Evaluation System). A CURES report allows a clinician to verify that the patient is receiving controlled substances from only one provider and from only one pharmacy to comply with their pain management contract. In addition, patients should undergo frequent (usually at least quarterly) random urine drug testing to confirm that they are not abusing any illicit drugs which would also be a violation of their pain management contract.

61. Respondent never ran a CURES report or performed any urine drug screens on the Patient to confirm compliance. This represents a simple departure from the standard of care.

62. Failure to ever run a CURES report or perform any urine drug screens represents a simple departure from the standard of care.

63. There was insufficient psychological evaluation and screening for substance abuse prior to initiation of chronic narcotics.

64. The standard of care for prescribing controlled substances for pain requires performing a thorough screening for psychological disorders and occult substance abuse prior to considering the initiation of chronic opioid therapy. This screening can include the use of the Opioid Risk Tool, depression screening with the PHQ-9 or Becks Depression test, or the CAGE-AID tool for risk of an alcohol use disorder, etc.

65. Respondent never documented any psychological screening, substance abuse disorder screening or depression screening for the Patient during his care.

66. Failure to perform any psychological screening, substance abuse disorder screening, or depression screening prior to or during chronic opioid therapy represents a simple departure from the standard of care.

Insufficient use of consultants for patients with ineffective pain management, mood disorders, and addiction

67. Business and Professions Code section 2241.5 (d) states that "A physician and surgeon shall exercise reasonable care in determining whether a particular patient or condition, or the complexity of a patient's treatment, including, but not limited to, a current or recent pattern of drug abuse, requires consultation with, or referral to, a more qualified specialist." The care of a patient with a history of substance abuse or addiction requires extra monitoring, documentation, and often consultation with an addiction specialist.

68. The Patient had a dual diagnosis disorder and ineffective pain management of his chronic nonmalignant pain. Chronic opioid and benzodiazepine use is very risky and challenging in a Patient with a substance abuse disorder, opioid addiction, and has both depression and anxiety. In addition, the pain seemed to be worsening despite escalating doses of both opioids and benzodiazepines signifying an inadequate pain management plan. In addition, Respondent clinically suspected a central spinal stenosis of the lower spine which may require surgical intervention if present. Finally, the Patient had a seizure of unclear etiology. No referrals were made to any physical therapist, pain specialist, neurologist, spine specialist, or mental health professional.

69. Failure to obtain any consultation for the numerous problems this Patient had represents a simple departure from the standard of care.

Inadequate medical record keeping

70. The standard of care for prescribing controlled substances for pain requires that all physicians keep accurate and complete records to include all of the elements stated above.

71. Respondent failed to document a narcotics contract, medication informed consent or his recommendation to obtain referrals or to perform diagnostic imaging.

72. Poor and insufficient documentation of these key areas represents a simple departure from the standard of care.

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THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

73. By reason of the facts set forth above in Paragraphs 71 through 73, Respondent Bach Kim Nguyen, M.D., is subject to disciplinary action under section 2266 of the Code for failure to maintain adequate and accurate records of medical care and treatment.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A-92027, issued to Bach Kim Nguyen, M.D.;

2. Revoking, suspending or denying approval of his authority to supervise physician assistants and advanced practice nurses;

3. If placed on probation, ordering him to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: July 31, 2017

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

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